FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017319

Facility Name: ALDEN LAKELAND REHAB & HCC

Address: 820 WEST LAWRENCE AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36-2687662

Date of Initial License for Current Owners: 01/01/72

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
	[ ] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code ____			[X] Corporation		[ ] Other ____
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other ____		

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,343	1,747	6,148	37,238	8
9	SNF/PED					9
10	ICF	24,801	776		25,577	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,144	2,523	6,148	62,815	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.37%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 178 and days of care provided 5,892

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	267,066	24,070	9,600	300,736	1,122	301,858	(5,126)	296,732			1
2	Food Purchase		477,748		477,748	(25,806)	451,942	(103,203)	348,739			2
3	Housekeeping	247,386	42,083		289,469	962	290,431		290,431			3
4	Laundry	86,696	27,665		114,361	168	114,529		114,529			4
5	Heat and Other Utilities			322,130	322,130		322,130	(2,198)	319,932			5
6	Maintenance	43,855		141,678	185,533	45	185,578	10,253	195,831			6
7	Other (specify):* Related Party Salary							53,646	53,646			7
8	TOTAL General Services	645,003	571,566	473,408	1,689,977	(23,509)	1,666,468	(46,628)	1,619,840			8
	B. Health Care and Programs											
9	Medical Director			63,000	63,000		63,000		63,000			9
10	Nursing and Medical Records	2,676,746	291,643	55,378	3,023,767	(141,338)	2,882,429	1,708	2,884,137			10
10a	Therapy	44,873			44,873		44,873		44,873			10a
11	Activities	91,994	1,510		93,504	280	93,784		93,784			11
12	Social Services	69,448		1,678	71,126		71,126		71,126			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							31,776	31,776			15
16	TOTAL Health Care and Programs	2,883,061	293,153	120,056	3,296,270	(141,058)	3,155,212	33,484	3,188,696			16
	C. General Administration											
17	Administrative	190,989			190,989		190,989		190,989			17
18	Directors Fees											18
19	Professional Services			921,976	921,976		921,976	(866,190)	55,786			19
20	Dues, Fees, Subscriptions & Promotions			142,679	142,679	(3,627)	139,052	(121,547)	17,505			20
21	Clerical & General Office Expenses	235,095	19,403	90,422	344,920	4,125	349,045	(103,254)	245,791			21
22	Employee Benefits & Payroll Taxes			631,487	631,487	14,777	646,264	(18,945)	627,319			22
23	Inservice Training & Education					23,084	23,084		23,084			23
24	Travel and Seminar			1,897	1,897		1,897	18,162	20,059			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			331,545	331,545		331,545	13,399	344,944			26
27	Other (specify):* Related Party Salary			141,918	141,918		141,918	341,567	483,485			27
28	TOTAL General Administration	426,084	19,403	2,261,924	2,707,411	38,359	2,745,770	(736,808)	2,008,962			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,954,148	884,122	2,855,388	7,693,658	(126,208)	7,567,450	(749,952)	6,817,498			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC #0017319 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			132,245	132,245		132,245	468,228	600,473			30
31	Amortization of Pre-Op. & Org.							3,405	3,405			31
32	Interest			148,044	148,044		148,044	659,455	807,499			32
33	Real Estate Taxes							337,653	337,653			33
34	Rent-Facility & Grounds			1,313,748	1,313,748		1,313,748	(1,313,748)				34
35	Rent-Equipment & Vehicles			11,666	11,666		11,666	31,000	42,666			35
36	Other (specify):* MIP & loss on sale of asset							127,356	127,356			36
37	**TOTAL Ownership**			1,605,703	1,605,703		1,605,703	313,349	1,919,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	682,314	707,234	1,081,455	2,471,004	126,208	2,597,212	(199,890)	2,397,322			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		3		3		3	(3)				41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	682,314	707,237	1,245,705	2,635,257	126,208	2,761,465	(199,893)	2,561,572			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,636,462	1,591,359	5,706,796	11,934,618		11,934,618	(636,496)	11,298,122			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Reporting Period Beginning 1/1/2005
Reporting Period Ending 12/31/2005

Reclassifications Pgs 3 and 4

From Line	To Line	Amount	Description	
2		(25,806.00)	Employee Meal	
	22	25,806.00	Employee Meal	
		-		
22		(11,029.00)	Uniforms	
	10	7,954.00	Uniforms	
	1	1,122.00	Uniforms	
	3	962.00	Uniforms	
	11	280.00	Uniforms	
	21	498.00	Uniforms	
	4	168.00	Uniforms	
	6	45.00	Uniforms	
		-		
10		(126,208.00)	Oxygen	126207.9
	39	126,208.00	Oxygen	
10		(23,084.00)	Dart Expense	
	23	23,084.00	Dart Expense	
20		(726.00)	Employee Background Checks	
	21	726.00	Employee Background Checks	
20		(2,901.00)	ehealth Data Solutions & Ext. Care Info	
	21	2,901.00	ehealth Data Solutions & Ext. Care Info	
		-		

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	82,422	30		9
10	Interest and Other Investment Income	(33)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,130)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(17,519)	21		17
18	Fines and Penalties	(497)	32		18
19	Entertainment	(4,672)	20		19
20	Contributions	1,294	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,874)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,918)	27		24
25	Fund Raising, Advertising and Promotional	(45,510)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(428)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (138,865)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(175,717)		34
35	Other- Attach Schedule	(321,914)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (497,631)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (636,496)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ALDEN LAKELAND REHAB & HCC

ID# 0017319

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees on Utilities	$ (5,464)	5	1
2	Late Fee on Telephone	(18)	21	2
3	Gift Shop Expenses	(3)	41	3
4	Intercompany Interest (GL 7031)	(143,076)	32	4
5	Other receipts g & a (gl 4977)	(473)	21	5
6	Marketing Manager	(146,627)	21	6
7				7
8	Back out 31.78% of PAC portion of IHCA	(4,004)	20	8
9	Employee Benefits Mrkt Mgr	(18,945)	22	9
10	Intercompany Interest(GL 7049)	(357)	32	10
11	bank charges on related party - Law.Av. Pg 6	(1,429)	21	11
12	To correct YTD depreciation expense	(1,337)	30	12
13	Eliminate refundable legal fees	(181)	19	13
14	Remove Loss on Sale of Asset from Line 20	(68,882)	20	14
15	Record Loss on Sale of Asset on Line 36	68,882	36	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(321,914)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(5,126)	0	0	0	0	0	0	0	(5,126)	1
2	Food Purchase	(1,130)	0	0	(102,073)	0	0	0	0	0	0	0	(103,203)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,464)	0	3,266	0	0	0	0	0	0	0	0	(2,198)	5
6	Maintenance	0	0	9,724	0	0	0	529	0	0	0	0	10,253	6
7	Other (specify):*	0	0	48,952	4,694	0	0	0	0	0	0	0	53,646	7
8	**TOTAL General Services**	(6,594)	0	61,942	(102,505)	0	0	529	0	0	0	0	(46,628)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	3,834	(2,126)	0	0	0	0	0	0	1,708	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	31,776	0	0	0	0	0	0	0	0	31,776	15
16	**TOTAL Health Care and Programs**	0	0	31,776	3,834	(2,126)	0	0	0	0	0	0	33,484	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,055)	9,979	(865,114)	0	0	0	0	0	0	0	0	(866,190)	19
20	Fees, Subscriptions & Promotions	(122,202)	0	655	0	0	0	0	0	0	0	0	(121,547)	20
21	Clerical & General Office Expenses	(166,066)	0	34,305	20,184	8,323	0	0	0	0	0	0	(103,254)	21
22	Employee Benefits & Payroll Taxes	(18,945)	0	0	0	0	0	0	0	0	0	0	(18,945)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	18,162	0	0	0	0	0	0	0	0	18,162	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	13,127	272	0	0	0	0	0	0	0	0	13,399	26
27	Other (specify):*	(141,918)	0	444,373	29,869	9,243	0	0	0	0	0	0	341,567	27
28	**TOTAL General Administration**	(460,186)	23,106	(367,347)	50,053	17,566	0	0	0	0	0	0	(736,808)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(466,780)	23,106	(273,629)	(48,618)	15,440	0	529	0	0	0	0	(749,952)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	81,085	377,247	8,035	0	1,861	0	0	0	0	0	0	468,228	30
31	Amortization of Pre-Op. & Org.	0	1,650	1,755	0	0	0	0	0	0	0	0	3,405	31
32	Interest	(143,963)	721,427	76,615	0	1,564	3,812	0	0	0	0	0	659,455	32
33	Real Estate Taxes	0	329,899	7,142	0	612	0	0	0	0	0	0	337,653	33
34	Rent-Facility & Grounds	0	(1,313,748)	0	0	0	0	0	0	0	0	0	(1,313,748)	34
35	Rent-Equipment & Vehicles	0	0	31,000	0	0	0	0	0	0	0	0	31,000	35
36	Other (specify):*	68,882	58,474	0	0	0	0	0	0	0	0	0	127,356	36
37	TOTAL Ownership	6,004	174,949	124,547	0	4,037	3,812	0	0	0	0	0	313,349	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(115,242)	(20,903)	(63,745)	0	0	0	0	0	(199,890)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(3)	0	0	0	0	0	0	0	0	0	0	(3)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(3)	0	0	(115,242)	(20,903)	(63,745)	0	0	0	0	0	(199,893)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(460,779)	198,055	(149,082)	(163,860)	(1,426)	(59,933)	529	0	0	0	0	(636,496)	45

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Alden Group Limited	100%	See pg 6K		See pg 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,313,748	Lawrence Avenue Building Partnership		$	$ (1,313,748)	1
2	V	32	Investment Income RR	994	Lawrence Avenue Building Partnership			(994)	2
3	V	19	Accounting Fees		Lawrence Avenue Building Partnership		8,400	8,400	3
4	V	33	Real Estate Tax Expense		Lawrence Avenue Building Partnership		329,899	329,899	4
5	V	26	Property and Liability Insurance		Lawrence Avenue Building Partnership		13,127	13,127	5
6	V	32	Interest on Mortgage Note		Lawrence Avenue Building Partnership		722,421	722,421	6
7	V	36	Mortgage Insurance Premium		Lawrence Avenue Building Partnership		58,474	58,474	7
8	V	30	Depreciation Expense		Lawrence Avenue Building Partnership		377,247	377,247	8
9	V	31	Amortization Expense		Lawrence Avenue Building Partnership		1,650	1,650	9
10	V	19	Misc. Admin Expense		Lawrence Avenue Building Partnership		1,579	1,579	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,314,742			$ 1,512,797	$ * 198,055	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$ 883,200	Alden Management Services		$ 18,086	$ (865,114)	15
16	V	21	Gen'l & Admin		Alden Management Services		34,305	34,305	16
17	V	5	Utilities		Alden Management Services		3,266	3,266	17
18	V	6	Maintenance		Alden Management Services		9,724	9,724	18
19	V	24	Travel & Seminar		Alden Management Services		18,162	18,162	19
20	V	26	Insurance		Alden Management Services		272	272	20
21	V	20	Dues, fees, & subscriptions		Alden Management Services		655	655	21
22	V	30	Depreciation		Alden Management Services		8,035	8,035	22
23	V	31	Amortization		Alden Management Services		1,755	1,755	23
24	V	33	Real Estate Taxes		Alden Management Services		7,142	7,142	24
25	V								25
26	V	35	Rent-Vehicles, etc		Alden Management Services		31,000	31,000	26
27	V	32	Interest		Alden Management Services		76,615	76,615	27
28	V	7	General Services Salaries		Alden Management Services		48,952	48,952	28
29	V	15	Health Care Salaries		Alden Management Services		31,776	31,776	29
30	V	27	General Admin. Salaries		Alden Management Services		444,373	444,373	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 883,200			$ 734,118	$ * (149,082)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube Feeding	$ 184,331	Prism Health Care		$ 82,258	$ (102,073)	15
16	V	1	Dietary Consultant	9,600	Prism Health Care		4,474	(5,126)	16
17	V	7	Dietary Salary and Wages		Prism Health Care		4,694	4,694	17
18	V	10	Equipment Rental	3,060	Prism Health Care		6,894	3,834	18
19	V	39	Supplies	286,767	Prism Health Care		106,988	(179,779)	19
20	V	39	Vent Rental		Prism Health Care		64,537	64,537	20
21	V	27	Genl & Admin Salaries		Prism Health Care		29,869	29,869	21
22	V	21	Genl & Admin Expenses		Prism Health Care		20,184	20,184	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 483,758			$ 319,898	$ * (163,860)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 175,314	Forum Extended Care II		$ 249,513	$ 74,199	15
16	V	10	House Stock	8,349	Forum Extended Care II		7,405	(944)	16
17	V	39	IV	110,567	Forum Extended Care II		16,151	(94,416)	17
18	V	27	Employee Vaccine	1,195	Forum Extended Care II		935	(260)	18
19	V	10	Pharmacy Consulting	9,210	Forum Extended Care II		8,028	(1,182)	19
20	V	39	Wound Care Kits	3,159	Forum Extended Care II		2,473	(686)	20
21	V	27	Gen'l & Admin Salaries		Forum Extended Care II		9,503	9,503	21
22	V	21	General & Admin.		Forum Extended Care II		8,323	8,323	22
23	V	32	Interest		Forum Extended Care II		1,564	1,564	23
24	V	33	Real Estate Tax		Forum Extended Care II		612	612	24
25	V	30	Depreciation		Forum Extended Care II		1,861	1,861	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 307,794			$ 306,368	$ * (1,426)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 1,062,950	Community Physical Therapy	100.00%	$ 999,205	$ (63,745)	15
16	V	32	Interest		Community Physical Therapy		3,812	3,812	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,062,950			$ 1,003,017	$ * (59,933)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	$ 22,542	Alden Bennet Construction	0.00%	$ 23,071	$ 529	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,542			$ 23,071	$ * 529	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

ALDEN NURSING CENTER - Lakeland **# 0017319** **Report Period Beginning 01/01/05** **Ending: 12/31/05**

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Waterford	Aurora
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Northmoor	Chicago
ANC Princeton	Chicago
Alden Orland Park	Orland Park
Alden of Old Town West	Bloomingdale
Alden Trails	Bloomingdale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Prism Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Thereapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	President	President	Chief Executive	100.00	131,836	2.196	5.49	salary	$ 7,664	27-7	1
2	Nurse coordinator	Nurse coordinator	nursing admin.	0.00	71,592	2.196	5.49	salary	4,162	15-7	2
3	Maint. Supervisor	Maint. Supervisor	construct/mainten	0.00	48,671	2.196	5.49	salary	2,829	7-7	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of The Alden Group, Limited										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 14,655		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	mortgage	$87,518.00	8/27/02	$ 11,977,000	$ 11,640,294	8/26/42	6.1400	$ 722,421	1
2												2
3												3
4												4
5	Other Therapeutic Systems		X								4,114	5
	Working Capital											
6	related party - AMS & other	X		working capital							76,615	6
7	related party - CPT	X		working capital							3,812	7
8	related party - FECII	X		working capital							1,564	8
9	TOTAL Facility Related				$87,518.00		$ 11,977,000	$ 11,640,294			$ 808,526	9
	B. Non-Facility Related*											
10	Interest Income on RR										(994)	10
11	Interest Income (4646,4975)										(33)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,027)	14
15	TOTALS (line 9+line14)						$ 11,977,000	$ 11,640,294			$ 807,499	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 58,474 Line # 36

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	325,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	322,699	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,501)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	332,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	329,899	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	337,570	8
	2001	346,350	9
	2002	350,233	10
	2003	315,686	11
	2004	322,699	12

accrual based on 2% increase over last year.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN LAKELAND REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0017319

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-419-040-0000	Nursing Home Facility	$ 326,699.00	$ 326,699.00
2.	See Attached	Related Party - Alden Management	$ 130,007.00	$ 7,142.00
3.	See Attached	Related Party - Forum	$ 15,792.00	$ 612.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 472,498.00	$ 334,453.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,500 B. General Construction Type: Exterior brick Frame steel Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	300 Bed Facility		1995	$ 1,040,001	1
2					2
3	TOTALS			$ 1,040,001	3

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	related party-forum			1978	$ 14,541	$	25	$	$	$ 14,541	4
5	300			1978	8,882,363	222,111	40	222,059	(52)	65	5
6			1995		577		40	14	14	2,559,934	6
7			1995		245		40	6	6	63	7
8				1996	13,250		40			2,953	8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
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35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GENERAL REMODELING	1994	$ 1,640,753	$ 42,645	15	$ 109,384	$ 66,739	$ 1,207,864	37
38	NEW AIR CONDITIONER	1994	185,718	4,827	15	12,381	7,554	130,664	38
39	OXYGEN AND SUCTION SYSTEM	1994	89,080	2,315	15	5,939	3,624	64,992	39
40	3RD FLOOR NURSES STATION	1994	14,234	370	15	949	579	10,109	40
41	REBUILD SHOWERS AND STALL	1994	47,131	1,225	15	3,142	1,917	33,912	41
42	PATIENT ROOM LIGHTING	1994	34,763	903	15	2,318	1,415	24,690	42
43	CARPETING	1994	20,688		10			17,306	43
44	NEW DOOR LOCK AND HARDWARE	1994	25,312		10			21,382	44
45	VARIOUS OTHER ITEMS	1994	85,896		10			55,265	45
46	DECORATING	1986	5,000		3			5,000	46
47	DOCORATING,PUMPS, ROOF REPAIR, COMPRESSOR REPAIR	1987	15,543		3-5			15,543	47
48	ELECTRICAL REPAIRS, CARPENTRY,PUMP REPAIR	1988	15,804		5			15,804	48
49	PUMP REPAIR	1989	2,510		5			2,510	49
50	REPAIR: PUMPS AND COMPRESSOR	1990	32,782		5-10			32,782	50
51	REPAIR: PUMPS, FANS, HEATER,ROOF	1991	16,753		5			16,753	51
52	REPAIR: BOILER,FANS, THERMOSTAT	1992	32,033	59	5-20	58	(1)	32,091	52
53	COLOR RENDERING,REPAIR: COOLING TOWER, ELECT TIMER,	1993	8,916	490	5-15	490		7,725	53
54	DRAPERIES AND CUBICLES; COMPRESSOR REPAIR	1994	45,438	1,256	5-20	1,256		43,256	54
55	REPAIR: ELEVATOR, LAUNDRY ROOM, PUMPS,A.C, INSULLATIO	1995	415,705	22,315	5-20	22,315		261,657	55
56	NEW ELECTRIC GENERATOR, NEW COOLING TOWER	1996	191,725	9,510	5-20	9,510		95,036	56
57	INSTALL NEW CIRCUITS	1997	2,176		5			2,176	57
58	CLEAN FAN COILS	1997	4,622		5			4,622	58
59	REPAIR LIGHTING CIRCUIT & BALLAST	1997	2,327		5			2,327	59
60	REBUILD COMPRESSOR	1997	4,268		5			4,268	60
61	REPAIR CALL LIGHTS	1997	2,350		5			2,350	61
62	ISTALL NEW SMOKE DETECTOR	1997	2,661		5			2,661	62
63	SPRAYED FIREPROOFING	1997	3,965		5			3,965	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,859,129	$ 308,026		$ 389,820	$ 81,794	$ 4,694,265	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,859,129	$ 308,026		$ 389,820	$ 81,794	$ 4,694,265	1
2	Climate Service, Inc (replace fans)	1998	4,725		5			4,725	2
3	**'Wigdahl(replaced outlets)	1998	2,300	230	10	230		1,821	3
4	Wigdahl(replaced outlets)	1998	334	33	10	33		264	4
5	Long Elevator(modify restrictors)	1998	2,200	110	20	110		862	5
6	Incorporation(kickplates & correr guards)	1998	2,309	77	5	77		2,309	6
7	Incorporation(kickplates & larone)	1998	4,547	227	5	227		4,547	7
8	Shine Rite Maintenance (strip and refinish 30 rooms)	1998	6,480	324	5	324		6,480	8
9	Star Contractors (install locks)	1998	5,581	558	10	558		4,372	9
10	Supreme Sheet Metal (Fire dampers)	1998	10,000	667	15	667		5,000	10
11	CSI (replace fan coil units)	1998	6,340	423	15	423		3,100	11
12	Atash Fire & Safety (install annunciator panel)	1998	5,890	393	15	393		2,978	12
13	CSI (rebuild compressor)	1998	7,056	470	15	470		3,449	13
14	Supreme Sheet Metal (install fire dampers)	1998	11,680	1,168	10	1,168		8,468	14
15	Alden Bennett Construction (plan of correction)	1998	2,222	222	10	222		1,592	15
16	Supreme Sheet Metal (install fire dampers)	1998	7,750	775	10	775		5,490	16
17	Supreme Sheet Metal (install fire dampers)								17
18	Patton (repair generator)	1999	1,702	113	15	113		794	18
19	Alden Bennett Construction(general)	1999	11,471	1,147	10	1,147		7,360	19
20	Welding Supply(oxygen piping installed)	1999	13,176	659	20	659		4,118	20
21	ISS/Chicago Sound &Comm.(call system)	1999	28,500	1,900	15	1,900		11,717	21
22	Alden Bennett Construction(general)	1999	23,560	1,571	15	1,571		9,555	22
23	Alden Bennet Construction- oxygen tank	1999	9,475	474	20	474		2,843	23
24	Alden Bennett Construction(oxyg tank)	1999	35,016	1,751	20	1,751		10,576	24
25	Supreme sheet metal-install fire dampers-delete duplicate	2000	(9,475)	(948)	10	(948)			25
26	Climate Service, Inc (repair boiler)	2000	4,892	245	20	245			26
27	A&B custom cable-install cable tv	2000	13,824	1,382	10	1,382		7,948	27
28	Fox Valley-install new fire safety pump	2000	4,423	221	20	221		1,271	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,075,107	$ 322,218		$ 404,012	$ 81,794	$ 4,805,904	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,075,107	$ 322,218		$ 404,012	$ 81,794	$ 4,805,904	1
2	Fox Valley-repair hvac pump	2000	1,969	98	20	98		566	2
3	System electric-circuit for sump pump	2000	2,361	118	20	118		669	3
4	System electric-emergency lighting	2000	5,190	346	15	346		1,932	4
5	System Electric-install circuits	2000	1,570	78	20	78		431	5
6	Fox Valley-install tank system	2000	1,755	70	25	70		386	6
7	GT Mechanical-repair boiler	2000	2,698	135	20	135		742	7
8	ABC-fireproofing	2000	2,503	125	20	125		667	8
9	ABC-seal & stripe parking lot	2000	977	98	10	98		505	9
10	Richard G. Radke-color rendering	1993	6,620		5			6,620	10
11	Remodeling-Lawrence Ave Partnership (building)	1994	140,050	3,501	40	3,501		38,513	11
12	ABC-oxygen tank wiring	2000	26,715		3			26,715	12
13	ABC-wallpapering	2000	3,543		3			3,543	13
14	EWS - Oxygen tank repairs	2001	2,157	270	8	270		1,259	14
15	Simplex Time Recorder (fire alarm repairs)	2001	1,810	121	15	121		553	15
16	Simplex Time Recorder (fire alarm repairs)	2001	1,529	102	15	102		467	16
17	GT Mechanical-replace trane rooftop unit	2001	17,800	1,187	15	1,187		5,340	17
18	Long Elevator-repair elevator	2001	757	76	10	76		335	18
19	Long Elevator-replace boards	2001	4,659	466	10	466		2,058	19
20	Alden Bennett - various	2001	1,720	172	10	172		788	20
21	Alden Bennett - various	2001	8,688	579	15	579		2,558	21
22	Alden Bennett - various	2001	11,481	765	15	765		3,253	22
23	Medline Industries	2002	1,205	120	10	120		391	23
24	GT Mechanical-replace relay board/compressor	2002	1,696	113	15	113		396	24
25	CSI Coker- booster heater	2002	5,238	349	15	349		1,367	25
26	Alden Bennett -building improvement	2002	3,358	224	15	224		840	26
27	Alden Bennett -building improvement	2002	2,478	248	10	248		764	27
28	Alden Bennett -building improvement	2002	3,161	316	10	316		1,027	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,338,794	$ 331,895		$ 413,689	$ 81,794	$ 4,908,589	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,338,794	$ 331,895		$ 413,689	$ 81,794	$ 4,908,589	1
2	GT Mechanical-rebuild compressor	2003	6,500	433	15	433	0	1,264	2
3	Simplex Grinnell -replace smoke detectors	2003	4,225	423	10	423	(0)	1,233	3
4	Simplex Grinnell-repair fire pump	2003	2,094	209	10	209	0	558	4
5	Simplex Grinnell fire system connection	2003	1,710	171	10	171		456	5
6	CSI Coker-Hobart dishwasher	2003	1,522	304	5	304		735	6
7	Simplex Grinnell-2 duct smoke detectors	2003	1,620	162	10	162	0	378	7
8	Simples Grinnell-2 duct smoke detectors & electric	2003	1,961	196	10	196	(0)	441	8
9	GT Mechanical-repair boiler	2003	1,340	268	5	268	0	581	9
10	GT Mechanical-replace boiler relief valve	2003	931	186	5	186	0	403	10
11	Alden Bennett Cons.-roof repair & rails installed	2003	7,517	752	10	752	(0)	1,692	11
12	GT Mchanical-back up pump bearing	2004	1,713	171	10	171		314	12
13	GT Mchanical-main house pump	2004	1,555	156	10	156		260	13
14	GT Mechanical-cooling towwe repairs	2004	1,259	125	10	125		969	14
15	CAPPS Plumbing-replaced kitchen faucets, drains	2004							15
16	ABC-repair kitchen,freezer doors and misc repairs	2004	8,038	804	10	804		1,340	16
17	Oak First Signal Circuit-elevator repair	2004	2,075	208	10	208		312	17
18	ABC misc repairs	2004	6,005	600	10	600		950	18
19	GT Mechanical-laundry motor replacement	2004	2,966	297	10	297		445	19
20	GT Mechanical-cooling gtower fan motor	2004	4,181	418	10	418		627	20
21	ISS/chicao Sound/ repair address sound	2004	2,092	209	10	209		296	21
22	ABC misc repairs	2004	5,832	583	10	583		826	22
23	GT Mechanical-A/C for East side of bldg	2004	1,007	101	10	101		143	23
24	System Electric-walk in cooler lights	2004	904	60	15	60		80	24
25	Oak First-installation of smoke dectors in front of elevators	2004	6,500	650	10	650		813	25
26	Top Notch-repaired faucet/drains	2004	1,627	163	10	163		177	26
27	ABC-Medical Gas Revisions	2004	27,009	2,700	10	2,700		4,726	27
28	CAPPS Plumbing-replaced kitchen faucets, drains	2005	1,320	132	10	132		132	28
29	Cybor Fire Protection Fire Sprinkler	2005	3,195	190	7	190		190	29
30	ABC New water cooling system	2005	153,553	4,479	20	4,479		4,479	30
31	ABC New water cooling system	2005	12,097	252	20	252		252	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,611,142	$ 347,298		$ 429,092	$ 81,794	$ 4,933,662	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,611,142	$ 347,298		$ 429,092	$ 81,794	$ 4,933,662	1
2	Related Party-Forum:								2
3	Leasehold Improvement-Remodeling	1980	11,034		15			11,034	3
4	Leasehold Improvement-Remodeling	1980	17,284		20			17,284	4
5	Leasehold Improvement-Tenant Improvement	1987	893		13			893	5
6	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	6
7	Leasehold Improvement-Roof	1994	3,203	200	16	200		2,204	7
8	Leasehold Improvement-Build.Improv.	1996	1,129	71	16	71		702	8
9	Leasehold Improvement-Asphalting	2000	88		3			88	9
10	Leasehold Improvement-DAI	2001	154	15	10	15		64	10
11	Leasehold Improvement-Bathrooms	2002	667	76	7	76		242	11
12	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		491	12
13	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,801	329	7	329		465	13
14	Leasehold Improvement-Add-on Improvement, fixture base	1980	71		23			71	14
15	Leasehold Improvement-Add-on Improvement, lighting base	2001	123	25	5	25		117	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	694	7	694		1,997	28
29	Leasehold Improvement-Remodeling	2003	5,085	726	7	726		2,072	29
30									30
31									31
32	Forum Extended Care, LLC-building/building improv	1999	12,928	306	30	306	0	2,139	32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,692,378	$ 349,904		$ 431,699	$ 81,794	$ 4,993,802	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,843,320	$ 162,680	$ 162,680	$ 0		$ 1,333,153	71
72	Current Year Purchases	38,697	4,307	4,307			4,307	72
73	Fully Depreciated Assets	291,499	1,676	1,676			291,499	73
74								74
75	TOTALS	$ 2,173,516	$ 168,663	$ 168,663	$ 0		$ 1,628,960	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Related Party AMS	Various Bus/Auto	1998-2004	4,706	111	111		3	4,638	77
78										78
79										79
80	TOTALS			$ 4,706	$ 111	$ 111	$		$ 4,638	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,910,601	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 518,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 600,473	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 81,794	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,627,399	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party Rent is eliminated
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 3/31/04
Ending 3/31/14

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 1,197,708
13.	12/31/2007	$ 1,197,708
14.	12/31/2008	$ 1,197,708

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 11,666 Description: Copy machine rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	Related party-AMS		#######	31,000	19
20					20
21	TOTAL		$ #######	$ 31,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   skilled nurses on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 210,932	$		$ 210,932	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			60,110			60,110	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			209,232			209,232	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See page 16a	# of prescrpts				249,513		249,513	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1, 39-3		682,314			131,428		813,742	12
13	Other (specify): see pg 16a					(63,745)	917,537		853,792	13
14	TOTAL			$ 682,314		$ 416,529	$ 1,298,478		$ 2,397,322	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Alden - Lakeland
PA pg 16
For the Thirteen Months Ending December 31, 2005

Page 16
Col 5: PT,OT, & ST
Col 6: Supplies

XIV. Special Services (Direct Cost)

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Col 5	210,932
2. ST	39-3	To Col	60,110
3.			
4. PT	39-3	To Col	209,232
5.			
6.			
7.			
8.			
Phamacy Supplies per GL			175,314
Manual Input from Related Party- Forum Drugs			74,199
9. Total to line 9 Pharmacy	See Pg 16A	To Col	249,513
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Col.	682,314
12. Exceptional Care-Supplies:	See pg 16A	To Col.	131,428
Total Exceptional Care (Line 12, Col 8)			813,742
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To Cc	(63,745)
Other			1,001,673
Manual Input: Related Party - Pyramid			(115,242)
Manual Input Related Party Wound Vac			(686)
Manual Input: Related Party FECII - I.V.			(94,415)
Oxygen, from reclass worksheet			126,208
13. Col 6: Supplies Total		To Col 6	917,538
13. Total Line 13, Column 8			853,793
14. Total			2,397,322

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC **#** 0017319 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 5	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 140,000)	2,533,999	2,533,999	3
4	Supply Inventory (priced at)	264	264	4
5	Short-Term Investments			5
6	Prepaid Insurance		49,058	6
7	Other Prepaid Expenses	2,125	2,125	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,536,388	$ 2,585,451	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,040,001	13
14	Buildings, at Historical Cost		8,884,435	14
15	Leasehold Improvements, at Historical Cost	1,542,497	4,076,743	15
16	Equipment, at Historical Cost	683,477	2,094,687	16
17	Accumulated Depreciation (book methods)	(1,484,859)	(5,777,341)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		65,981	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,499)	20
21	Restricted Funds		438,986	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 741,115	$ 10,817,993	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,277,503	$ 13,403,444	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,470,723	$ 3,563,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	112,138	112,138	28
29	Short-Term Notes Payable	26,117	26,117	29
30	Accrued Salaries Payable	449,626	449,626	30
31	Accrued Taxes Payable (excluding real estate taxes)	79,332	79,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)		332,400	32
33	Accrued Interest Payable		60,007	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accr ins, exps, idpa, sales tax	395,737	395,737	36
37	Due to affiliates	11,411,428	10,272,088	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 15,945,101	$ 15,290,496	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,640,294	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,640,294	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,945,101	$ 26,930,790	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (12,667,598)	$ (13,527,346)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,277,503	$ 13,403,444	48

***(See instructions.)**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (10,947,618)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (10,947,618)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,719,980)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,719,980)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (12,667,598)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,616,452	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,616,452	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	87,528	6
7	Oxygen	345,199	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 432,727	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	755	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	158,178	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,933	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Write off old A/P	6,493	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,493	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,214,638	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,689,977	31
32	Health Care	3,296,270	32
33	General Administration	2,707,411	33
	B. Capital Expense		
34	Ownership	1,605,703	34
	C. Ancillary Expense		
35	Special Cost Centers	2,471,007	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,934,618	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,719,980)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,719,980)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,056	2,144	$ 82,665	$ 38.56	1
2	Assistant Director of Nursing	887	929	32,661	35.16	2
3	Registered Nurses	40,349	42,716	1,314,587	30.78	3
4	Licensed Practical Nurses	29,390	31,064	800,651	25.77	4
5	CNAs & Orderlies	95,806	101,561	1,065,446	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,684	5,985	97,014	16.21	8
9	Activity Director	1,768	1,982	34,923	17.62	9
10	Activity Assistants	6,271	6,800	57,071	8.39	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,944	2,056	34,101	16.59	13
14	Head Cook	5,881	6,200	72,561	11.70	14
15	Cook Helpers/Assistants	16,663	18,075	160,404	8.87	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,080	43,855	21.08	17
18	Housekeepers	23,165	25,068	247,386	9.87	18
19	Laundry	7,136	7,837	86,697	11.06	19
20	Administrator	2,024	2,080	135,578	65.18	20
21	Assistant Administrator	2,032	2,080	55,411	26.64	21
22	Other Administrative	7,525	7,702	266,621	34.62	22
23	Office Manager					23
24	Clerical	3,814	4,028	43,983	10.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	217	217	2,405	11.08	31
32	Other Health Care(specify)					32
33	Other(specify) Pro Care Manager	80	80	2,442	30.53	33
34	TOTAL (lines 1 - 33)	254,572	270,684	$ 4,636,462 *	$ 17.13	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	800/mo	$ 9,600	1-3	35
36	Medical Director	5250/mo	63,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	600/mo	7,200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	252	11-3	44
45	Social Service Consultant	4	234	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	$ 80,286		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Risa Glantz	administrator		$ 135,578
Helen Cofield	assistant Administrator		55,411
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 190,989

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 883,200
BDO Seidman	Accounting Fees	5,563
Ken Fisch/Greenburg	Legal Fees	10,923
Medi-com	consultant-prof	1,046
SMS	billing consultant	5,126
Gerber	Legal fees-union contract	2,410
MAS	Software Consulting	1,230
Pathway	nursing consultant	937
Dana Consulting	401k Services	667
Ken Fisch/Greenburg	Legal Fees collections	9,204
Record Copy	Medical records	1,670
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 921,976

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,391
Unemployment Compensation Insurance	54,578
FICA Taxes	325,472
Employee Health Insurance	41,324
Employee Meals	25,806
Illinois Municipal Retirement Fund (IMRF)*	338
Union,Health, Welfare	49,580
Pension	27,593
dental & life insur	1,174
miscell empl costs	9,197
vaccinations/drug tests	3,811
Marketing Employ.Benefit deduction	(18,945)
TOTAL (agree to Schedule V, line 22, col.8)	$ 627,319

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	782
Health Care Worker Background Check	
(Indicate # of checks performed 66)	464
IL Health Care Assoc	14,300
Surety Bonds	1,305
Related Party - AMS	654
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,505

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party - AMS	18,162
auto & travel	823
gasoline	595
Seminar Expense	
IHCA	479
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,059

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	hvac/pipes/pumps/repairs	1/88	$ 3,500	5	$	$	$	$	$	$	$	$	$
2	hvac/pipes/pumps/repairs	2/88	2,444	5									
3	hvac/pipes/pumps/repairs	3/88	2,385	5									
4	hvac/pipes/pumps/repairs	7/88	1,766	5									
5	hvac/pipes/pumps/repairs	10/88	3,200	5									
6	hvac/pipes/pumps/repairs	12/88	2,510	5									
7	boiler/hvac repair	6/89	5,114	5									
8	fan/pump/boiler repairs	10/90	4,240	5									
9	fan/pump/boiler repairs	11/90	3,482	5									
10	fan/pump/boiler repairs	12/90	2,233	5									
11	see page 22a	1991-1995	220,093	5-20	1,540	1,540	1,540	1,540	1,540	1,540	1,540	1,540	
12	see page 22b	1996	41,372	3-20	696	696	696	696	555	505	505	505	
13	see page 22c	1997	16,366	3									
14	see page 22c	1998	103,843	3	0								
15	see page 22d	1999	18,157	3	3,021	0							
16	painting>$1,500 ytd 1999	7/99	12,619	3	2,103	0							
17	see page 22d	2000	15,388	3	5,129	2,964	133	0					
18													
19													
20	TOTALS		$ 458,712		$ 12,489	$ 5,200	$ 2,369	$ 2,236	$ 2,095	$ 2,045	$ 2,045	$ 2,045	$

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **14,300**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,303** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,806** Has any meal income been offset against related costs? **no** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? n/a
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **BDO Seidman** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.